SMMGP

Substance Misuse Management in General Practice Newsletter

'The 4th National Conference: Management of Drugs Users in General

Practice' Friday April 23rd 1999

Royal Institute of British Architects, Portland Place, London

"A Time of Change - Has Anything Changed?'

Royal College of General Practitioners, HIV / AIDS Working Party

A one day conference to continue the debate about working with drug users in primary care

- The Government drugs strategy and its implications.
- Treatment works but what and how?

Hoping you can enjoy this edition of the newsletter at the conference or by post if you were unable to attend. If you are not on the usual mailing list and would like to be see details of how to join at the end of this newsletter.

Drug Misuse and Dependence - Guidelines on Clinical Manaagement Dept of Health, The Scottish Office, Dept of Health Welsh Office, Dept of Health & Social Services, Northern Ireland

These long overdue guidelines are now completed and are hopefully to be launched by Tessa Jowell, Minister for Public Health on 12.4.99. The final version will be kept under embargo, even to members of the working group until the day of the launch. We will focus attention on the guidelines at the above conference and begin to look at how they are going to influence our way of working. We will discuss their content and possible impact in the next newsletter and continue the debate begun at the conference.

High dose buprenorphine - what is its role in substitute prescribing for opiate users?

High dose buprenorphine is now available in the UK for prescription by any doctor for the treatment of opiate misuse. Marketed under the trade name of Subutex, the sublingual tablets are available in 0.4mg, 2mg and 8mg strengths. Buprenorphine has been tested in 33 trials involving over 2,500 patients in France and USA, and its effectiveness in opiate substitute prescribing has been demonstrated. In France, where methadone is only available from specialist clinics, high dose buprenorphine has been extensively used by GPs since 1996. Over 55,000 clients have been treated. What will its place be in treatment in primary care in the UK?

What is different about buprenorphine?

Buprenorphine acts as a partial agonist at the u-receptor site in the brain. These are the receptors believed to be responsible for non-analysis effects of opiates such as euphoria, respiratory depression and dependence. It is this partial agonist property of buprenorphine that gives it most of the advantages it is said to have over methodone, which is a full agonist:

- 1) low risk of respiratory depression when used alone (though the risk when used concurrently with other respiratory depressants is not yet known)
- 2) lower dependence liability, making it better for use for detox
- 3) blockade of other opiates reducing concomitant use of street drugs
- 4) limited development of tolerance
- 5) long half life possibility of alternate day dosing and less difficult withdrawal

What are the disadvantages?

Some disadvantages compared with methadone seem to be:

- 1) only available as tablet potential for injecting (this may be able to be addressed by incorporating naloxone into the tablet)
- 2) euphoric effect of low doses (e.g. as in Temgesic) gives a high street diversion potential 8mg tablet can be divided up into smaller doses and sold
- 3) not powerful enough to hold patients using >1/2G heroin or 50mg + of methadone.
- 4) has been licensed as a Schedule 3 drug this means cannot be prescribed in instalments on the blue FP10 MDA
- 5) urine screening being developed but not yet routinely available will cost about £5 per test
- 6) not licensed for use in pregnant women
- 7) cost for treatment (excluding dispensing cost) of 8mg/day is £2.80 (compare 50mg methadone 0.80p)
- 8) product sheet suggests 'regular' monitoring of LFTs because of side effect of hepatitis

A possible role for buprenorphine

It is being recommended for use in maintenance and detoxification treatments. Its role in primary care, if any, seems likely to be for younger, shorter term heroin users. It may also be helpful for patients on longer term methadone treatment who are trying to reduce and come off - a switch from methadone to buprenorphine at the 30mg methadone level is straightforward, and the resulting detox may be easier and quicker than with methadone.

Launching this new treatment

Although Subutex can now be prescribed, a low key approach to launching it into the substance misuse treatment arena has been adopted. It is not being advertised. The plan is first to introduce it into specialist clinics with appropriate training for staff and evaluation of its use. This fits with the new clinical guidelines. It may then be investigated for use for suitable patients in primary care. Obviously its use in any setting will be limited unless interval prescribing is possible.

Special consideration is being given to its introduction in Scotland, given the Temgesic epidemic and subsequent voluntary ban on low dose buprenorphine prescribing there in recent years. Plans are being developed to try and monitor the extent of any street diversion of prescribed

Subutex. Obviously there are concerns about the possibility of profligate prescription by private

practitioners. It could well be popular amongst opiate users getting private scripts because of its injectable potential, and profitability if resold in smaller doses.

Conclusion

It seems unlikely that the arrival of high dose buprenorphine onto the market will revolutionise our management of opiate misuse in the future. It may have a useful role in the treatment of the less heavily dependent user, and in detox. It is to be hoped that further trials will be carried out in specialist clinics and in primary care, to clarify the best use of buprenorphine as a treatment option in appropriate clients.

Berry Beaumont, GP, 2 Mitchison Rd, London N1 3NG

Footnote - I attended the first national meeting of the Subutex discussion group in January 1999. This was convened and funded by Schering-Plough and consisted of specialists in substance misuse with myself included to represent primary care. There will be future meetings but I have not committed myself to attending these. If any other GP would like to be invited, please let me know. Thank you.

What do the 'guidelines' say about buprenorphine?

In line with the above article with the following addition:

'It is recommended that buprenorphine should be initiated by a specialist practitioner, and safeguards such as daily dispensing, with supervised consumption, should be inherent to any well-delivered buprenorphine substitution programme. The ready solubility and injectability of this substance makes it a substance that requires longer term supervised dispensing but this could be reviewed when a product that combines buprenorphine and naloxone becomes available in the future. Given the limited experience in the UK with this new form of buprenorphine, it is recommended that through evaluation be conducted to explore the possible benefits and drawbacks that may be conferred by this new pharmacological option.'

A Review of Shared Care Protocols for the treatment of problem drug use in England, <u>Scotland and Wales</u>

Claire Gerada, James Tighe BJGP, February 1999 P 125-129

In 1995, the Dept of Health instructed health authorities to establish protocols for the shared care of problem drug users. Response to this was disappointing: only 26 out of 120 health authorities have shared care arrangements in place, with the content of these differing widely.

'A joint working group of the RCPsy and the RCGP concluded that shared care can be achieved if there is close GP/specialist contact, integrated training/audit/agreed protocols, and clear responsibility for prescribing. Sadly, we are far from this ideal.'

[&]quot;Buprenorphine: Licensed for the management of drug dependence"

<u>Hepatitis C Infection, Prevention, Treatment and Injecting Drug Users - shunned by the International Medical Community?</u>

On February 26-27 th 1999 there was an International Hepatitis C Consensus meeting organised by the European Association for the Study of the Liver (EASL) in Paris, France. One of the most significant groups affected by Hepatitis C - injecting drug users, were virtually ignored. There were numerous presentations and a consensus statement was developed:

- what are the public health implications of Hepatitis C?
- what is the natural history of Hepatitis C?
- · diagnostic tests
- who should be screened for Hepatitis C?
- how can the transmission of Hepatitis C be prevented?
- which patients should be treated?
- which patients should not be treated?

'Active intravenous drug users should not be treated due to the risk of reinfection. In addition, compliance with treatment is poor in patients in whom alcoholism has not been interrupted and in whom drug addiction continues.'

Nigel Hughes RN, Clinical Nurse Specialist HIV & Virology and Chair of Mainliners commented 'Without a doubt, Hepatitis C, and possibly other infections of this ilk to come, have joined HIV as the most significant human rights issue facing drug users globally, internationally and nationally, and we continue to ignore and reject this issue at our extreme peril.'

The full statement can be read on the EASL website:

http://www.munksgaard.dk/hepatology/easl/index.htm

BLACK POPPY

- A Publication by Drug Users for Drug Users

This is a new magazine which has just sent out its second issue. It is packed with good useful and accessible information on a range of topics - injecting practice, abscesses, DVT, overdose myths, as well as reviews, jokes and fun. I certainly will be filling in the subscription form to receive the next editions and will distribute it to the drug users I see in the surgery. The editors of the magazine will have a stall at the conference or you can contact them at Black Poppy Publications, The Caravan Needle Exchange, 6 South Wharf Road, London W2

- Read it, subscribe and distribute!

Newsletter edited by Chris Ford, Brian Whitehead and Rima Chowdhury. If you have contributions or suggestions please let us know. Or if you would like to join the mailing list for this newsletter, please contact: SMMGP Newsletter, Brent & Harrow Health Authority, Harrovian Business Village, Bessborough Road, Harrow HA1 3EX P:0181.966.1109 Fax:0181.426.8646